SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name: ______________________________ Date of Birth: _____________ Account#: ___________

As a Federally Qualified Health Center, Health Partnership Clinic (HPC) offers patients the opportunity for discounted fees determined by household size and annual household income. The Financial Assistance Application must be completed in full, and all required documentation submitted at time of the application. HPC requires re-verification of household size and income <u>every 12 months – or earlier if there is a change</u>.

<u>Please List All Household Members</u>: **Total # of Household Members: _________**

Name: (start with head of Household)	**Date of Birth:**	**Relationship:**	**Income:**	**HPC Acct#**
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	
			YES / NO	

Families larger than 10 request additional form

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Please select all that apply to all member of the household

Wages	**YES**	**NO**
Social Security	**YES**	**NO**
Cash Assistance	**YES**	**NO**
Business Income, self-employment	**YES**	**NO**
Unemployment, worker's compensation, disability, strike benefits, etc.	**YES**	**NO**
Child Support – Alimony	**YES**	**NO**
Educational grants, loans, and awards	**YES**	**NO**
Investment Properties/Rental Income	**YES**	**NO**

If your income is $0, how are you meeting your food, clothing, shelter, and transportation needs?

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By signing below, I certify that the HPC staff may contact each employer listed and/or agencies to confirm my income. I have provided HPC with proof of income for the purpose of determining my discount. I will be asked to reapply for the program every 12 months or earlier if there is a change. I agree to inform HPC if there are changes to my income, household size, or insurance coverage. I understand that certain services and/or items cannot be discounted. I understand that HPC can only apply discounts to services provided by HPC. While HPC may have agreements with outside providers to offer services at a discount, I understand it will be my responsibility to directly apply for financial assistance for any services I have been referred to by HPC. I agree to pay my assigned slide level fee at the time of services. I understand that falsified documentation is subject to penalty and can disqualify me or family members from the program. I hereby certify that the information I provide is correct.

______________________________ ______________________________

Applicant Signature **Date**

______________________________ ______________________________

Guardian or Power of Attorney Signature **Date**

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INTERNAL OFFICE USE ONLY:

Account#: ______________________

Combined Annual Income: ______________________

Discount Level Assigned: ______________________

Effective Date: ______________________

Application Approved By: ______________________